MEDICAL ASSISTANCE ADMINISTRATION
DME PROGRAM MANAGEMENT UNIT (DMEPMU)
PO BOX 45506
OLYMPIA WA 98504-5506

NEGATIVE PRESSURE WOUND THERAPY

All spaces MUST be completed by the nursing staff caring for the client.

All information must be current within 30 days of service dates. You must keep appropriate documentation to substantiate this information in your files.

A current dated photo of the wound and a copy of the physician's prescription must accompany this form.

CLIENT'S NAME		PIC NUMBER
NAME OF NURSING FACILITY/NURSING SERVICE/HOME HEALTH AGENCY	TELEPHONE NUMBER	FAX NUMBER
RX PHYSICIAN	TELEPHONE NUMBER	FAX NUMBER
SERVICE DATES INFORMATION IS FOR:		
ESTIMATED LENGTH OF TREATMENT:		

CLIENT SPECIFIC INFORMATION

HEIGHT	WEIGHT	IDEAL BODY WEIGHT	LIFE EXPECTANCY IN MONTHS/YEARS	TURNING SCHEDULE	AMBULATORY STATUS

DIAGNOSES

What are all of the client's medical conditions/diagnoses?

Are these conditions controlled/stable? ☐ Yes ☐ No

If no, please specify:

MENTAL/BEHAVIOR

Rate the following: **A**lways, **S**ometimes or **N**ever

Alert: ☐ A ☐ S ☐ N Oriented: ☐ A ☐ S ☐ N Compliant with care: ☐ A ☐ S ☐ N

COMMENTS

NUTRITIONAL/DIETARY STATUS

1. Tube fed? ☐ Yes ☐ No	2. Self fed? ☐ Yes ☐ No With Assist? ☐ Yes ☐ No	3. Total daily calories?	4. Number of calories needed for healing:

5. List all nutritional supplements given:

WOUND TYPE

1. Surgical? ☐ Yes ☐ No

If yes,

a. Type of Surgery
b. Date of Surgery
c. Date of dehisced

2. Pressure? Yes ☐ No ☐

If yes,

a. Support surface in use? ☐ ☐
   1) If yes, what kind/name?
b. Moisture/Incontinence managed? ☐ ☐

3. Neuropathic (Diabetic) Ulcer? Yes ☐ No ☐

If yes,

a. Patient on a comprehensive diabetic management program? ☐ ☐
b. Are patient's blood sugars within normal limits? ☐ ☐

4. Venous Stasis Ulcer? Yes ☐ No ☐

If yes,

a. Compression bandages/garments consistently applied? ☐ ☐
b. Is leg(s) elevated? ☐ ☐
c. Is client ambulating? ☐ ☐

5. Has client been hospitalized in the last two years? ☐ Yes ☐ No

If yes, give dates and reasons:

LABS

DATE DRAWN:

1. Albumin: 2. Hematocrit: 3. Hemoglobin: 4. If diabetic, need HgbA1C:

WOUND EVALUATION: (Must be current stage not "healing stage")

	A.	B.	C.
Location			
Size (Width & Length)			
Depth			
Stage			
Tunneling			
Drainage			

1. Address color, odor, type and amount of exudates (none, minimum, moderate, or heavy)

2. Is wound clean and free of necrotic tissue/eschar? ☐ Yes ☐ No

   If no, why?

	Yes	No
3. Is untreated osteomyelitis present within the vicinity of the wound?	☐	☐
4. Is cancer present in the wound?	☐	☐
5. Is there a fistula to an organ or body cavity within the vicinity of the wound?	☐	☐

6. What is onset date of the wound(s)?

7. List <u>all</u> treatments/dressings tried prior to NPWT; i.e, wet/dry dressing, antibiotic powders, hydrocolloid dressings, and absorbent bandages.

8. Why were previous treatments discontinued or considered ineffective?

9. Does the client have Home Nursing? ☐ Yes ☐ No

If no, why? _____

10. Is there a caretaker at home who can be trained to change the dressing? ☐ Yes ☐ No

If yes, how many times per day? _____

If no, please describe why not:

_____

_____

_____

_____

11. What other conditions does the client have that may result in decreased healing?

_____

_____

_____

_____

_____

12. List all medications:

_____

_____

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13. If this request is for an extension beyond the first month rental of the therapy system, a weekly wound summary is required. If there has not been a substantial improvement in wound status, please provide an explanation why; to include, what changes in treatment are being implemented to improve healing potential.

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ADDITIONAL COMMENTS:

NURSING STAFF SIGNATURE	DATE
TITLE	